Future Management of Alcoholism in Ontario

February, 1965

Alcoholism and Drug
Addiction Research Foundation
An Agency of the Province of Ontario

ALCOHOLISM & DRUG *Addiction Research Foundation*

AN AGENCY
OF THE PROVINCE
OF ONTARIO

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BRANCHES — LONDON, OTTAWA, HAMILTON AND LAKEHEAD

Feb. 26, 1965.

The Hon. Matthew B. Dymond, M.D.,
Minister of Health,
Parliament Buildings,
Toronto, Ontario.

Dear Dr. Dymond:

Enclosed herewith is a summary for a total program to deal with the problem of alcoholism and problem drinking in Ontario.

Yours very sincerely,

S. R. Stevens,
Chairman.

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INTRODUCTION

In the following, we present a report containing a summary of a plan for the overall management of the problems of alcoholism in their various forms in Ontario. Much of the material is summarized in chart and point form on the first few pages of the report. More detailed material is contained in some of the appendices.

By way of further summary the following points should be noted:

1. At the present time, society generally accepts alcoholism and problem drinking in all of its various aspects as a problem of public health. The Government of Ontario at the present time recognizes this in part through the establishment of the Alcoholism and Drug Addiction Research Foundation under the Department of Health. On the other hand, the concept is denied by another section of government which is forced to regard those who are chronically dependent on or addicted to alcohol as petty criminals.

2. The Province of Ontario could take a very major step forward in this field if a forthright policy statement endorsed by all members of the legislature could be made. This policy statement should perhaps read something as follows: To declare alcoholism and problem drinking a public health problem requiring for its prevention and control a complete program of research, education and information, early detection, treatment and rehabilitation. If such a policy is adopted then we could foresee the Foundation playing an important role in its implementation.

3. One of the first steps would be to hold a series of meetings with senior representatives of relevant government departments and community agencies in order to plan in detail the overall approach.

After 15 years of experience in this field which includes intensive study of worldwide activities, we are convinced that over a number of years this very large public health problem can be successfully managed and prevented. It will need, of course, considerable ingenuity, determination, and widespread community and government support.

There is no doubt that the public of Ontario is now ready for such an approach.

H. David Archibald
Executive Director
Alcoholism and Drug Addiction
Research Foundation

FUTURE MANAGEMENT OF ALCOHOLISM IN ONTARIO

The existence in Ontario to-day of about 100,000 alcoholics along with a smaller number addicted to other types of drugs, is a substantial challenge in the domain of public health. This Province is in a better position to face such a challenge than most others. The experiment of prohibition was not successful. Therefore the solution must be sought by other means.

Since its formation fifteen years ago by the Ontario Government, the Alcoholism and Drug Addiction Research Foundation has become nationally and internationally known for the high standard of its clinical effort, the imagination and effectiveness of its educational program and the carefully documented output from its research. With such experience behind us, we can now with considerable confidence set forth an outline plan for a massive attack on this problem over the next few years.

We do not by any means have all the answers; however, we have learned enough to be able to attack large segments of the problem and to build into our whole plan of campaign the kind of intelligence or feedback mechanism of research that will eventually fill the gaps in our knowledge.

I. SUMMARY

(1) Ontario's present alcoholic population of 90,000 - 100,000 people will reach 120,000 in 20 years unless in the meantime our prevention and treatment activities are substantially expanded.

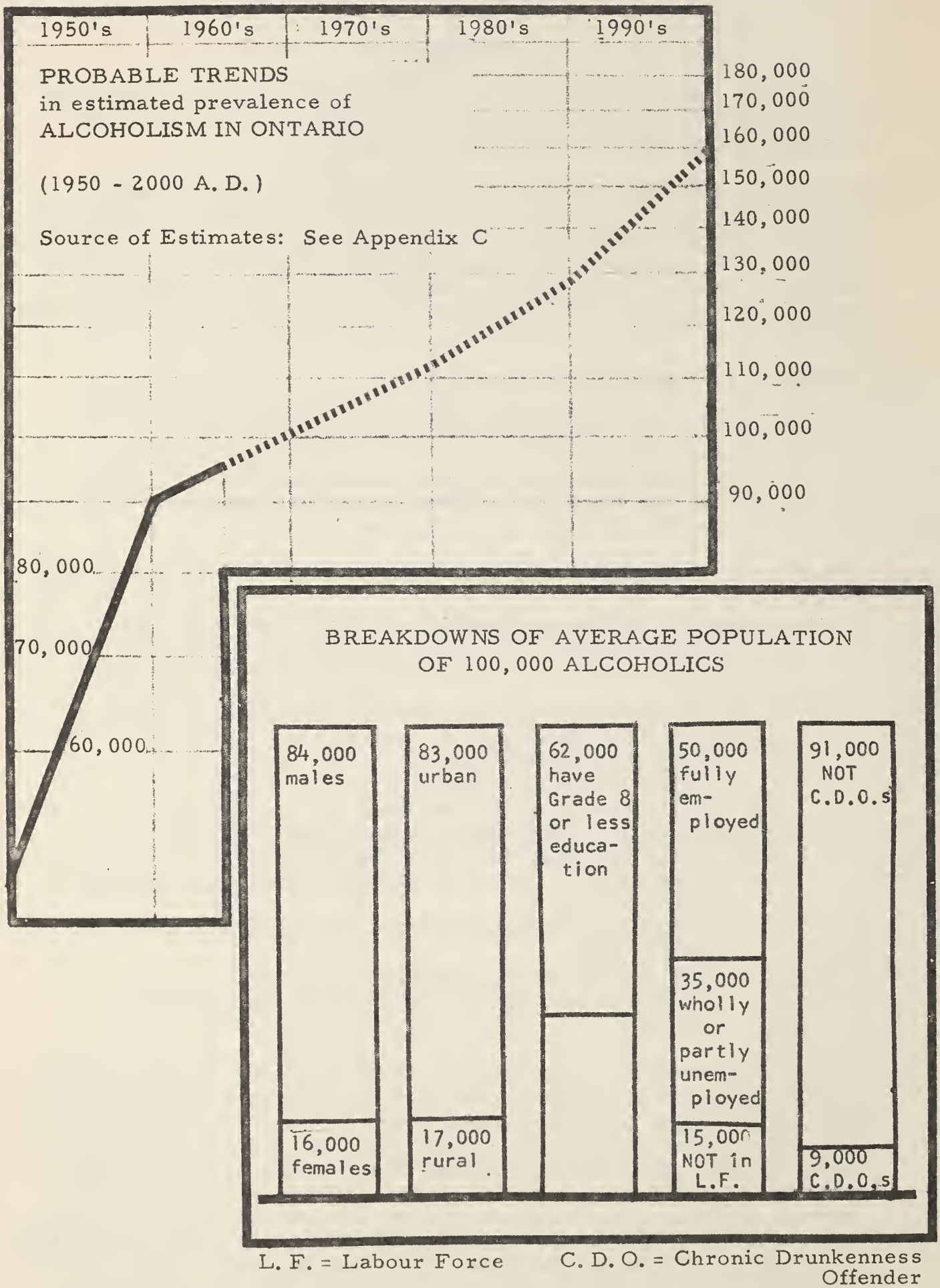
(2) The Ontario Legislature should declare alcoholism a public health problem requiring for its prevention and control a complete program of education and information, early detection, treatment and rehabilitation, together with continuing research. The Alcoholism and Drug Addiction Research Foundation could play a leading role in such a program in cooperation with other government and private organizations and agencies of Ontario.

(3) PREVENTION will be achieved mainly by:
   a) expanding the present youth education programs in the schools;
   b) expanding the advertising and publicity reaching adults;
   c) developing industrial programs with a view to the earliest possible recognition and treatment of pre-alcoholic symptoms;
   d) developing and expanding existing community programs for early detection and treatment of alcoholism.

(4) TREATMENT of alcoholism should be considered separately for three main groups:
   a) the employed alcoholic population of about 50,000, for whom industrially oriented staff and facilities are needed for diagnosis and outpatient treatment and referrals where needed to other facilities;
   b) the 40,000 individuals in the alcoholic population who are not employed and for whom there is a need for:
      (i) home and agency treatment;
      (ii) outpatient clinic treatment;
      (iii) day care and hospital treatment.
   c) the skid row and chronic drunkenness offender group of 9,000 - 10,000 for whom there is a need for:
      (i) changes in the law or its administration regarding public drunkenness;
      (ii) medically staffed detoxication and diagnostic units in major cities;
      (iii) small Halfway House rehabilitation units;
      (iv) rehabilitation farms for up to 3,000 semi-permanent occupants.

(5) While the Foundation now has in 7 out of Ontario's 10 economic regions, skeleton programs of research, education and outpatient treatment, the expanded treatment facilities proposed above call for a fourfold to fivefold increase in the number of professional personnel (physicians, social workers, psychologists, nurses, etc.) having some specialized training in the management of addictions. In order to provide the training required, the Foundation should establish as soon as possible small inpatient units in each of the 4 - 5 university centres in Ontario where health professional training is now concentrated. These inpatient units would serve both for treatment of patients and for training of professional personnel. A total of approximately 350 to 400 hospital beds is envisaged.

Studies conducted by the Alcoholism & Drug Addiction Research Foundation produce the following information.



L. F. = Labour Force C. D. O. = Chronic Drunkenness Offender

Graph is on proportionate (semi-logarithmic) scale
so that equal percentage changes show as equal differences in height

II. THE PROBLEM - ITS SIZE AND NATURE

The rate of prevalence of alcoholism increased sharply in the 1950's, but appears since then to have been stabilizing at 2 - 2½% of the adult population (lower than rates in the United States or France but higher than in some other European countries or Canadian provinces). If this rate neither improves nor worsens, then Ontario's population growth pattern will be accompanied by:

(1) an increase in the number of alcoholics from the present 90,000 - 100,000 range gradually up to the 120,000 - 130,000 range, which will be reached in 15 to 20 years;

(2) thereafter, a more rapid increase, unless in the meantime our preventive activities have made a most substantial impression within the enlarged generation (born in the late 1940's) that will by then have reached the most susceptible age.

It has been established that over a period of years, a majority - say four-fifths - of the fully employed alcoholics can be motivated or directed into treatment. The prospects of successful treatment are also greater with this group than with others; so one can plan on the basis of rehabilitating three-quarters of those treated. This yields 30,000 improved.

The second group - neither skid row nor fully employed - would be more difficult to locate and move into the treatment flow. One-quarter of them will seek treatment voluntarily over a period of time and another quarter may be encouraged by a variety of pressures. Given a 50% success rate, this would yield 10,000 improved.

The chronic drunkenness offender group could all be directed into treatment. Our research indicates that about 3,000 of these would be "incurable" and would, therefore, require long term institutional care, preferably of the "farm" type. Perhaps one-third of the remaining skid row type men might respond to one or other of a variety of therapies, yielding another 2,000 improved.

PREVENTIVE ACTIVITY

Teacher Training

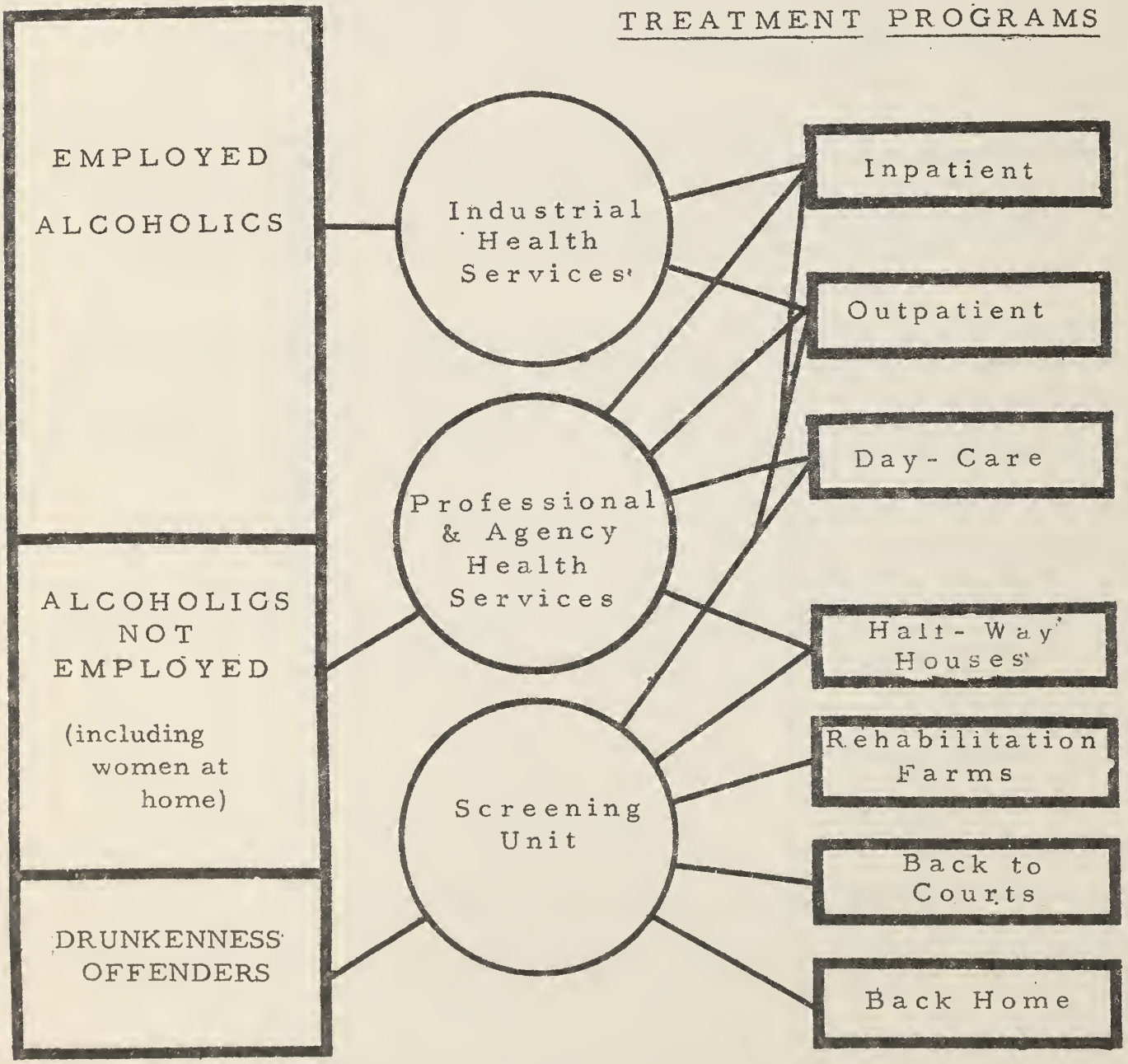
Advertising & Publicity

YOUTH

&

PARENTS

TREATMENT PROGRAMS



III. PRINCIPAL GOALS

The goals of the Government of Ontario in this field of public health, and of its agency, the Alcoholism and Drug Addiction Research Foundation, are twofold:

(1) to minimize the number of people who develop alcoholism; and
(2) to effect all possible improvement in the condition of those who, despite preventive endeavours, in the end become alcoholics.

Preventive activities are of two main types, primary (before any problem arises) and secondary (interrupting early stage alcoholism).

Primary prevention is fundamentally an educational task. Preventive education's main goals are:

(1) greater public understanding of and ability to recognize the ways of drinking that are harmful;

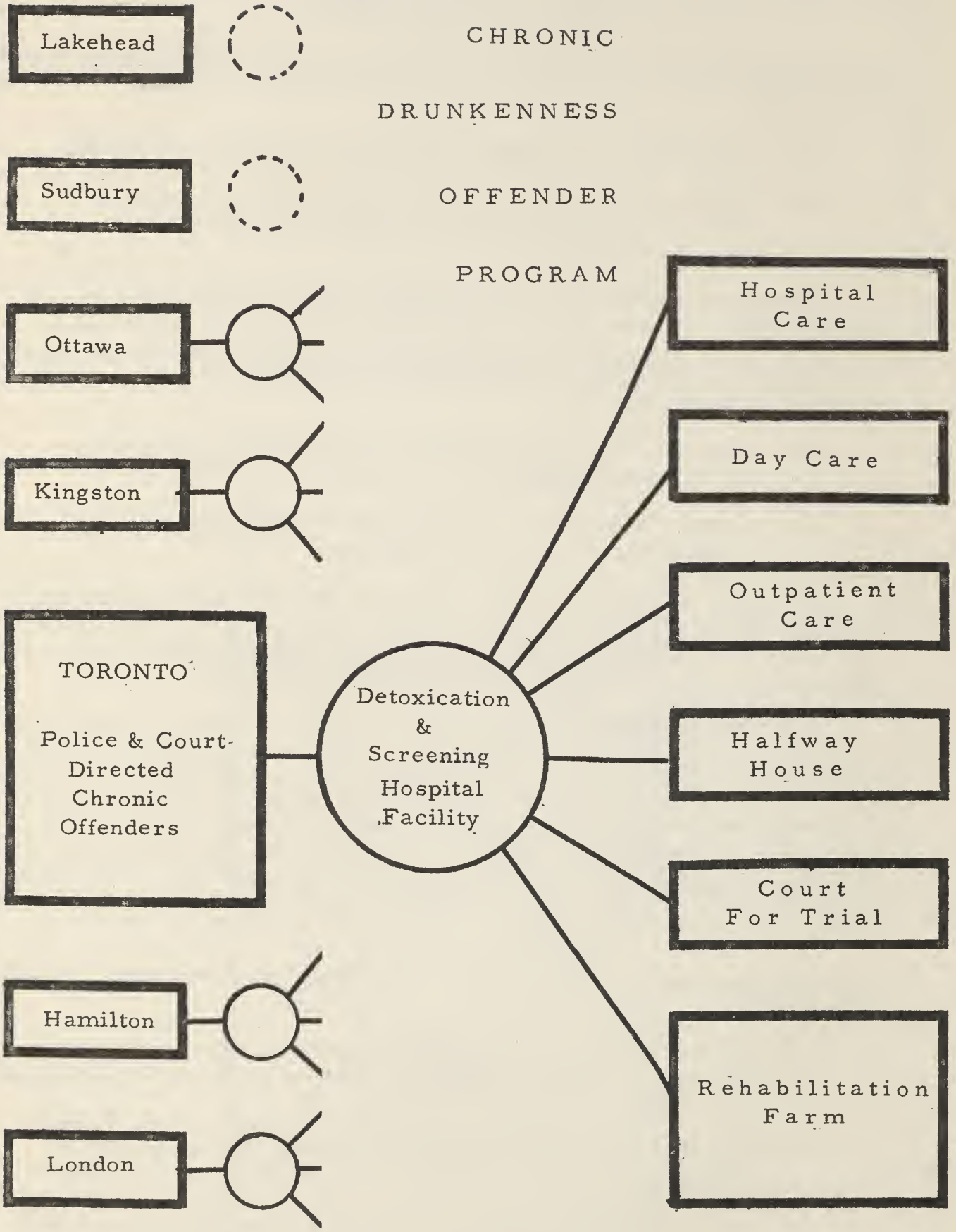
(2) a public tendency to consider drunkenness (not drinking) as something that is not tolerable.

Education of youth through teachers in schools needs reinforcing through parents and other adults who may be significant in the lives of young people. This calls for a considerably enlarged program of advertising, publicity, and public education generally.

Secondary prevention is basically a matter of case finding at the earliest possible stage in alcoholism's progressive development in the individual. One area where it can be expanded most effectively is through large employing organizations. Those in authority in employment settings need to start recognizing and handling early symptoms of developing alcoholism as reasons for insisting on referral to health services (instead of merely as misbehaviour to be tolerated or disciplined). This brings employed alcoholics into the treatment services before the rehabilitation problem has become too serious.

Treatment of alcoholics needs to be separately considered for three main groups:

(a) the fully employed alcoholic, who can be most easily found, encouraged to seek treatment and whose capacity for improvement is in general the least damaged;
(b) the less accessible non-employed alcoholics, whose average capacity for successful treatment would lie somewhere in between what would be expected of the first group and the skid row group;
(c) the much smaller group of socially deteriorated alcoholics, typified by the skid row habitué, whose chances of improving are minimal and who, therefore, requires a somewhat different approach.


CHRONIC
DRUNKENNESS
OFFENDER
PROGRAM
Lakehead
Sudbury
Ottawa
Kingston
TORONTO
Police & Court-Directed Chronic Offenders
Hamilton
London
Detoxication & Screening Hospital Facility
Hospital Care
Day Care
Outpatient Care
Halfway House
Court For Trial
Rehabilitation Farm

IV. THE CHRONIC DRUNKENNESS OFFENDER

The chronic drunkenness offender or "skid row" section of this problem:

(a) involves a relatively small group of people who nevertheless represent a large continuing cost to Ontario's police, courts and reform institutions;

(b) contains a large number of "incurable" cases (about) one third);

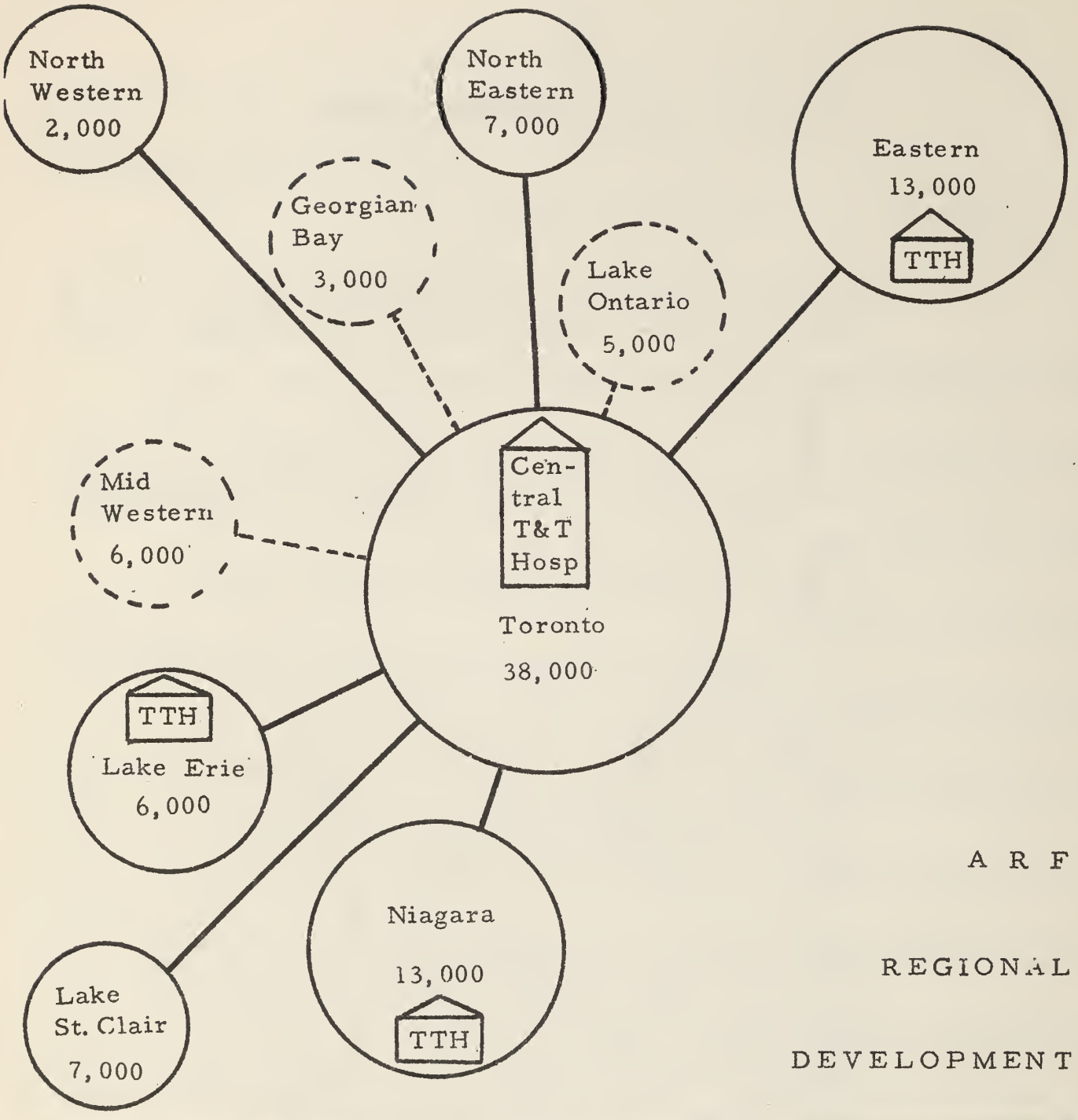
However, it appears possible to halve this problem by removing much of its repetitive aspect. For this purpose it is recommended:

(a) that provision be made for police to take publicly intoxicated persons to hospitals or other health facilities instead of to jails.

(b) that in seven cities (and eventually in more) there be established detoxication and diagnostic facilities as screening units, staffed with medical and other treatment personnel, all inebriates arrested to be taken there directly by the police. (In communities where no such offender screening unit exists, all inebriates arrested should be interviewed by a probation officer and, if possible, a physician prior to their release or their appearance in court.)

(c) that initially three rehabilitation camps for chronic public inebriates be established within the Province, applications for an order of commitment for an indeterminate period to be made either by the director of an offender screening unit, or by a chief of police when no centre exists, to a court of summary jurisdiction. The latter application should be accompanied by a pre-sentence report from a probation officer and an opinion from a medical doctor. The director of the residential treatment centre should be empowered to release a patient when, in his opinion, the patient is capable of leading a sober life in the community, or other arrangements for his care have been made.

(d) that a system of Halfway Houses be set up specifically for chronic public inebriates, admission to be voluntary.



Numbers in circles indicate approximate number of alcoholics in each region out of a provincial total of 100,000. They include the minority who are chronic drunkenness offenders for whom special procedures and facilities are described on the preceding page

Regional Education, Treatment & Research Program

Treatment Training Hospital

V. PROVINCE WIDE DEVELOPMENT OF SERVICES AND QUALIFIED STAFF

After deleting the skid row problem we are left with the two groups with the best chance of recovery, both of which will require:

(a) short term medical and (sometimes) hospital handling of withdrawal from episodes of acute intoxication. (This is not the major problem and will tend to be handled more and more in community hospitals as these become less crowded and the doctors on their staffs develop greater skill and interest in dealing with alcoholics.)

(b) treatment for the chronic or addiction aspect of their alcoholism in relation to "voluntary" patients, i.e., those not under police jurisdiction.

Disregarding (a) (the acute withdrawal problem) for the time being, we are left mainly with the need for treatment of the addiction aspect of alcoholism, in day care, outpatient and Halfway House facilities, plus some other health and welfare services which can treat alcoholism incidental to other problems.

The Foundation plans to develop its own research, educational and outpatient services on a basis related to the 10 economic regions adopted by the Province. (In seven of these the Foundation has a core of regional staff.)

In order to staff all services in this field, at least four to five times the present number of specially qualified physicians, social workers, psychologists, nurses and others will be needed. This calls for placing clinical training facilities at the top of the following priority list:

(1) Specialized treatment training hospitals at the major existing medical school centres, i.e., Toronto (now started), Kingston, Ottawa, London and eventually Hamilton. (Treatment teams trained in such facilities can then be used to expand the Foundation's regular regional programs with emphasis on the following.)

(2) Industrially oriented outpatient clinics (where there is the greatest potential gain in number of cases to be successfully handled before developing to a seriously deteriorated stage).

(3) Community outpatient and day treatment centres.

(4) Halfway Houses, to assist in post-treatment rehabilitation of all types of patients.

VI. RECOMMENDATIONS

(1) The Ontario Legislature should declare alcoholism a public health problem, requiring for its prevention and control a complete program of education and information, early detection, treatment and rehabilitation, together with continuing research. The Alcoholism and Drug Addiction Research Foundation should play a leading role in cooperation with other government and private organizations and agencies in Ontario.

(2) All interested government departments and independent organizations should collaborate on the implementation of the following recommended steps to deal with the problem of chronic drunkenness offenders, first on a pilot basis in Toronto and later, on a smaller scale, in each of several other communities:

a) establishment of (i) a 200 bed detoxication and screening hospital, (ii) several in-town "Halfway House" rehabilitation homes, (iii) at least one large out-of-town rehabilitation farm;

b) modification of any court or police procedures that may need to be changed to facilitate effective use of these special treatment centres.

(3) In order to deal more effectively with the large proportion of Ontario alcoholics who are not chronic offenders, the Foundation's existing network of regional outpatient treatment and educational programs within at least seven of the Province's 10 economic regions should be expanded as rapidly as possible.

(4) Since the expansion of all treatment facilities referred to depends on the availability of sufficient professional staff having specialized training in this field, the treatment training hospital now planned for a location on the University of Toronto campus should be completed as rapidly as possible, and similar but smaller treatment training hospitals should be established in other university centres in which the training of personnel for the health professions is concentrated.

(5) In order to do all possible to minimize the number of persons who become alcoholics in the future, the current program of youth education by secondary school teachers should be reinforced by expanded advertising, publicity and other public education measures designed to reach parents and others whose influence is important to young people reaching maturity.

VII. PROJECTED BUDGETS

1965 - 66	Estimated Operating Cost	1974 - 75
	EXISTING SERVICES AND DIVISIONS	
$ 726,960	Regional Outpatient and Education Programs	$ 1,800,000
301,070	Central Outpatient and Day Care Services	830,000
290,530	Education Division	950,000
339,180	Central Research Division	830,000
246,450	Administration	480,000
	NEW TREATMENT TRAINING HOSPITALS	
- -	In University Centres (other than Toronto)	3,000,000
355,900*	In Toronto	4,000,000
	NEW SERVICES	
- -	Halfway Houses, Rehabilitation Farms, etc.	2,000,000
- -	Detoxication and Screening Units	4,000,000
$2,260,090		$17,890,000
1965 - 66		1974-75

* present unit (replacement under construction)

TEN YEAR SEQUENCE

Fiscal Year	Estimated Operating Cost
1965 - 66	$ 2,260,000
1966 - 67	3,200,000
1967 - 68	5,200,000
1968 - 69	7,200,000
1969 - 70	9,200,000
1970 - 71	11,200,000
1971 - 72	13,200,000
1972 - 73	15,200,000
1973 - 74	16,200,000
1974 - 75	17,890,000

VIII. APPENDICES

APPENDIX A

ALCOHOLISM IN RELATION TO OTHER ADDICTIONS

Addiction is a state of ill health which arises from one or another form of excessive or abnormal dependence on a particular kind of substance and/or activity. Most frequently this involves the consumption of some chemical. Addiction to alcohol remains the main focus of our attention, for several reasons.

a) While some other addictions (e.g. cigarette smoking) have a hold on far more people, the existence of alcoholism in some 2½% of our adult population has serious ill effects on a great many more than this afflicted group itself, particularly among dependents of the alcoholics but also through other public dangers such as accident proneness.
b) From a treatment viewpoint, addictions to other substances, particularly drugs like barbiturates, amphetamines and tranquillizers, frequently appear in the same persons as alcoholism; hence they often involve the same organization for treatment services.
c) From the viewpoint of preventive public knowledge and awareness, it is believed that most progress can be made by encouraging an attitude that regards abnormal use of alcohol in much the same light as dependence on drugs.

In regard first of all to alcoholism, and incidentally to other addictions, the goals of the Government of Ontario and its agency, the Alcoholism and Drug Addiction Research Foundation, remain essentially twofold:

1) to minimize the number of people who develop any such abnormal dependence on a substance;
and
2) to effect all possible improvement in the condition of those who, despite preventive endeavours, in the end become alcoholics or addicts to other chemicals.

To put various addiction problems in perspective one can state:

a) The Department of National Health and Welfare reports fewer than 1,000 narcotic addicts in Ontario;
b) Current estimated prevalence of alcoholism in Ontario approaches 100,000;
c) No accurate knowledge exists regarding addiction to non-narcotic drugs (barbiturates, amphetamines, tranquillizers, etc.), but based on some sample studies, an informed guess would place prevalence of this kind of addiction in the neighbourhood of 10,000.

APPENDIX B

PREVENTION

Alcoholism is a disease mainly of the middle-aged but which nevertheless has its roots in youth and young adulthood. Youth and young adulthood therefore represent prime targets for preventive activities.

Preventive activities are of two main types, primary (before any problem arises), and secondary (interrupting early stage alcoholism).

Primary prevention is fundamentally an educational task. There are some possible legislative approaches but their effectiveness is not established completely. It has been found that legal regulation of consumption is largely ineffective except where the economic effect of pricing is brought into play.

Secondary prevention is basically a matter of case finding. This, too, is a matter of education, or at least of public information, but there are also laws in relation to driving, drunkenness, and mental condition, which have a case finding effect. It is clear, too, that employers can do much to intercept the early development of alcoholism.

Education of a primary preventive nature needs to seek two main goals:

1) greater public understanding of and ability to recognize the ways of drinking that are harmful; and
2) a public tendency to consider drunkenness (not drinking) as something that is not tolerable.

Education of youth through teachers in schools needs reinforcing through parents and other adults who may be significant in the lives of young people at the age when they begin to experiment with drinking. In order to reach these adults, a considerably enlarged program of advertising and publicity is needed.

PRIME TARGETS - Young people (ages 14 to 24) are the most promising target for direct education; and their parents and teachers are the most productive targets for indirect education. (Approximately 45 per cent of Ontario's population was 24 years of age or younger at the last census.)

Research shows that a majority of teenagers experiment with alcohol before leaving high school, most begin at ages 13 or 14, and most at home in the presence of relatives. Most young people see drinking as a means of demonstrating their adulthood; and most model their drinking behaviour after the pattern of parents or other significant adults. Children of users of alcohol

APPENDIX B

PRIME TARGETS (continued)

will probably become users, and children of abstainers will likely abstain.

Research among parents brings agreement that young people are more influenced by their parents' example than by drinking behaviour seen in movies or on TV; and three out of four parents believe advertising increases the number of drinkers.

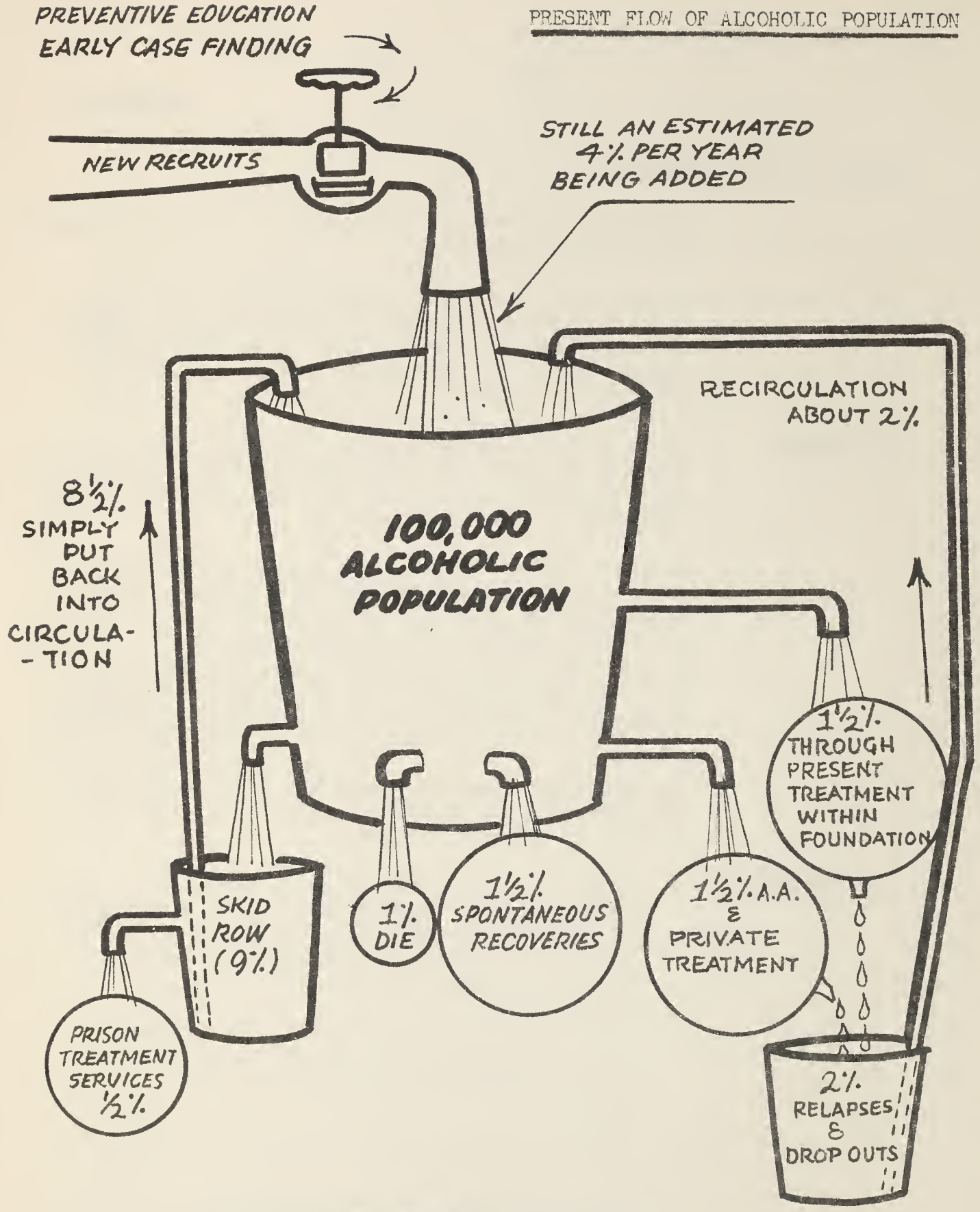
ADVERTISING - Analysis of alcoholic beverage advertising reveals the use of themes and illustrations that play directly upon the motivations noted by investigators as being influential in teenage drinking.

Appeal to these motivations could be appreciably reduced by limiting alcoholic beverage advertising to straight brand promotion without benefit of associated imagery. One Canadian distiller periodically advertises to promote moderation and to warn against such dangers as drinking and driving, drinking and hunting, etc. This suggests a socially useful form of advertising by the beverage industries.

The alcoholic beverage industries spent $12,576,000 on advertising in Canada in 1962 - an estimated 45 per cent of this in Ontario.

RECOMMENDATIONS -

1) In-school alcohol education as developed by the Alcoholism and Drug Addiction Research Foundation in collaboration with the Ontario Department of Education should be strengthened so all young people are exposed to it before leaving the school system.
2) Advertising and publicity addressed to adult social drinkers by the Foundation should be greatly increased and should stress the responsibility of adults as models for young people.
3) A radio campaign beamed directly at teenagers in their language should be launched.
4) The character and content of alcoholic beverage advertising in Ontario should be examined in the light of research conducted on a continuing basis by the Foundation.



PRESENT FLOW OF ALCOHOLIC POPULATION

Inflow		Outflow	
New Recruits	4%	Skid Row	9%
Recirculated:		Died	1%
Skid Row	8½%	Spontaneous Recovery	1½%
A.A., Priv. inst.	1%	A.A.& Priv. Inst.	1½%
Foundation	1%	Present treatment within Foundation	1½%
	14½%		14½%

APPENDIX B

Secondary prevention can be expanded most effectively through large employers. Those in authority in employment settings need to start recognizing and handling early symptoms of developing alcoholism as reasons for insisting on referral to health services (instead of merely as misbehaviour to be tolerated or disciplined). By such policies, employers can anticipate and try to prevent what would otherwise eventually cause loss of jobs by valuable personnel. These people have the greatest chance of rehabilitation and also are still likely to respond favourably to having continuation of employment made conditional on their acceptance of treatment.

The gradual spreading of such practices from those industries and other employing groups which now practise them into many other concerns is a sizable educational and liaison task. It must, of course, be integrated with other industrial and employee health programs, and for this reason it is proposed that a certain number of the clinical facilities proposed for addiction treatment be developed in collaboration with the health staffs presently employed by industry.

It appears that over a typical decade about 25% of the alcoholics disappear through death or spontaneous recovery. Yet from decade to decade, the total prevalence increases about 15%; hence about 40% per decade (a little less than 4% per year) is being, so to speak, added in at the bottom. In very rough figures, the challenge facing preventive programs is to cut from 4,000 to 2,000 or less the number of new alcoholics being created every year. If this is accomplished, then the problem will begin to diminish slowly.

APPENDIX C

STATISTICAL PROJECTIONS IN REGARD TO TREATMENT OF ALCOHOLISM IN ONTARIO

Estimates of the number of alcoholics are made in two ways - by surveys of the alcoholic population in representative areas and by use of what is known as the Jellinek Alcoholism Estimation Formula, this latter being based on a probable relationship between alcoholism prevalence and liver cirrhosis mortality.

In Ontario, both in 1951 and 1961, the Foundation made surveys of alcoholism prevalence in areas where the total population in many respects resembles in miniature the total population of the Province. By applying the area survey proportions of alcoholics by age groups to total Ontario populations by age groups, as forecast by the Ontario Department of Economics, one derives the following estimates of alcoholism prevalence for Ontario.

1961 - 86,000
1966 - 92,900
1971 - 99,500
1976 - 106,100
1981 - 112,700
1986 - 120,400

Further analysis of forecasted age group trends indicates that toward the end of the above period, the proportion of population in the age brackets most susceptible to alcoholism would begin to increase; hence it is clear that alcoholism would from then on begin to grow even more rapidly than the general population.

Even if one is fairly optimistic about preventive efforts, it seems clear that alcoholism is likely to involve at least 100,000 people for some time to come. These people require several kinds of treatment, so it is useful to start by establishing where such people are at any given point in time.

Geographically, they are distributed over the Province's 10 economic regions, approximately as follows:

Distribution of Alcoholic Population

1.	Eastern Ontario	13,000
2.	Northwestern	2,000
3.	Georgian Bay	3,000
4.	Lake Ontario	5,000
5.	Northeastern	7,000
6.	Midwestern	6,000
7.	Niagara	13,000
8.	Lake Erie	6,000
9.	Lake St. Clair	7,000
10.	Metropolitan Toronto	38,000
	Total	100,000

APPENDIX C

By combining information from sample studies, the following distribution by employment status and sex is derived.

Employment Status	Male	Female	Total
Fully employed	45,000	5,000	50,000
Transient, partly employed or unemployed	25,000	1,000	26,000
Not in labour force	6,000	9,000	15,000
Chronic drunkenness offenders and similar types	8,000	1,000	9,000
Total	84,000	16,000	100,000

It has been established that over a period of years a majority - say four-fifths - of the fully employed alcoholics can be motivated or directed into treatment. The prospects of successful treatment are also greater with this group than with others; so one can plan on the basis of rehabilitating three-quarters of those treated. This yields 30,000 improved, of whom 10% might be women.

The chronic drunkenness offender group could all be directed into treatment. It is estimated that at least 3,000 of these would have practically no chance of successful rehabilitation and would therefore require long term institutional care, preferably of the "farm" type. About half of this 3,000 could do some productive work in a protective setting but the rest would simply vegetate.

About one-third of the remaining skid row type men and some of the women may respond to one or other of a variety of therapies that would be indicated by intensive diagnostic study of each case. This yields another 2,000 improved. A partly controlled halfway house situation would be helpful to some of them; outpatient treatment would be sufficient with others. Even after eliminating the hopeless cases, the overall prognosis would be low with this group, so that 4,000 would likely keep relapsing back on to skid row and with further deterioration would eventually enter the long term care group.

Summing up the above projections, we have the following potential results:

APPENDIX C

	Employed Group	Skid Row Group	Remainder	Total
In permanent protective custody	-	3,000	-	3,000
Receiving treatment but relapsing	10,000	4,000	10,000	24,000
Receiving treatment and improving	30,000	2,000	10,000	42,000
Unreached	10,000	-	21,000	31,000
Total	50,000	9,000	41,000	100,000

APPENDIX D

PUBLIC HEALTH APPROACH TO THE CHRONIC DRUNKENNESS OFFENDER

1. The Role of the Police

The Liquor Control Act empowers the police to arrest, charge, and hold for trial anybody who is intoxicated in a public place but, of course, this power is used selectively. Our study has shown that the police tend mostly to arrest inebriates who are creating a disturbance or are likely to come to harm. It is recommended that public intoxication be no longer a punishable offence under the Liquor Control Act of Ontario. Inebriates who create public disturbance could still be charged under Section 160 of the Criminal Code.

The major shortcoming of the present system from the viewpoint of the police is that their activity leads to no improvement in the situation for reasons that lie beyond their control. The same individuals must be arrested and processed repeatedly at short intervals. The police object to a system that apparently does nothing to cure the troublesome behaviour and fails to keep offenders out of circulation for a long period in lieu of a cure.

Also there is the danger that the inebriate may be suffering from serious illness that appears to be intoxication or is masked by it, may have hidden injuries, or may be suicidal, and, as a result, die while in custody. No provision is made under the present system for treating intoxication as a form of genuine poisoning requiring medical attention as a matter of routine, although the police may take the arrested individual to a general hospital clinic if trouble is apparent to them.

The police, then, must continue to have the power to pick up inebriates who are disturbing others or endangering themselves but it does not follow that they must also continue to formally arrest them, jail them and bring them to trial.

If detoxication and diagnostic or screening centres, professionally manned and centrally located, were available in the larger centres, the police could be empowered by law to take inebriates into custody and transport them there. A program of education in alcohol problems for police officers, desirable under any system, would contribute to the efficient use of this facility insofar as it increased their ability to draw the line between those inebriates who require such attention and those who do not.

If inebriates who escaped police attention were allowed to go to the detoxication centre on their own initiative, or to be taken by friends or relatives, the role of the police would probably gradually diminish. Inebriates guilty of offences other than simple public intoxication might also be taken by the police to the detoxication centre, after which the necessary legal steps could be taken to secure their appearance in court.

APPENDIX D

2. Detoxication Centres

Ideally, the centre would be staffed and equipped to perform a variety of functions, but the need for certain services would depend on whether or not these were offered to this population by other organizations in the community and were available on a referral basis.

Each inebriate would be medically examined upon entry, and transportation provided to general hospitals for those with serious illness or injuries. Beds and medication would be available for sobering up. The staff would, of course, decide when a patient was fit to be released. Probably most could be sent home after a few hours. Many of those with jobs might thus avoid the dangers to their employment which goes with the present system of requiring them to appear in court in the morning. The patients with more serious withdrawal symptoms could be kept as long as was medically indicated.

The channelling of inebriates through the detoxication centre would provide an opportunity to detect personal problems and do something about them that is lacking and would be more difficult to arrange under the present system of funnelling them through the police cells and the courts. Social workers or other trained counsellors would interview the patients during their stay or by appointment at a later date. Hopefully, incipient alcoholism would be detected and candidates for the revolving door identified through the signs of developing alienation. It can be assumed that a large proportion of the patients would be homeless, unattached, and unskilled, and that a host of problems in addition to alcoholism would be uncovered.

What is to be done with the inebriate who returns repeatedly to the detoxication centre? We are justified in assuming that a considerable proportion of the men who are currently in and out of jail will be frequent customers despite efforts to help them on an outpatient basis. For this group, a long term residential treatment centre outside the city seems to be called for.

Since compulsion would be involved in sending men to residential treatment centres,legal sanctions would be necessary. A law might be enacted providing for the director of the detoxication centre (and perhaps other officials and interested parties in smaller centres lacking such a facility) to be permitted to apply to a court to have an individual committed to a residential treatment centre for chronic inebriates for an indefinite period, to be released at the discretion of the director. The law could also provide for the review at stated intervals of the cases of all individuals still under commitment in order to protect their civil rights.

The efficient operation of such a system presupposes the keeping of adequate clinical records on all individuals treated for intoxication.

APPENDIX D

3. Residential Treatment Centres

Magistrates and chief constables were asked for suggestions for handling the chronic drunkenness offender. The most frequent suggestion put forward is the establishment of some form of long term custody institution, preferably located in the country. The minimum expectation attached to this suggestion is that it would do away with the nuisance and futility of frequent arrest and court appearances. Some respondents feel, in addition, that healthful labour in a rural environment would have a beneficial effect. The most optimistic see this as an opportunity for long term treatment and retraining that would have a reasonable hope of success.

The findings of our study point to the conclusion that short term custodial treatment, at least in its present form, changes the behaviour of very few of the true chronic offenders. Given the characteristics of the chronic offender group uncovered in this and other studies, it is logical to expect that the process of re-education will be long and difficult, and will involve methods developed especially for this group.

The feasibility of operating a centre as a true treatment institution rather than as a modified prison or reformatory is enhanced by the fact that chronic drunkenness offenders are not usually security risks. Experience has shown that they rarely take the opportunity to escape from open institutions and that they create no danger to the public if they do. Within institutions, it is unusual for them to cause discipline problems. Not only are they generally tractable but they are also diligent and reliable workers while in these settings. As long as the facility is safely removed from the downtown city life, it could probably operate effectively as a completely open institution.

We lack the knowledge to specify the treatment and training regimens that would be effective. In our survey of treatment facilities elsewhere we came across no institutions that might serve as models for a thorough program. Since it has been shown that men of this type are the poorest bets for existing alcoholism treatment programs, it seems advisable that a long term treatment centre concentrated on the homeless alcoholic should have an experimental approach coupled with a systematic evaluation of results.

A good work program would be important both in defraying the costs of the facility and in the rehabilitation process. The idea of employing these men in farm labour seems to have wide public appeal, perhaps because this type of activity is associated in people's minds with health and good character, and perhaps because it is the type of work program easiest to arrange. The usefulness of this as a means of training men to hold jobs in an urban environment is open to question. Workshops that involve marketable skills should be available for the patients who seem at all likely to eventually become re-established in regular employment in the community. This does not rule out farm labour for the less hopeful cases.

To be most useful, the work program should replicate as far as possible the conditions of regular employment. The hours of work, methods of production, and supervisory organization might be modelled on those of a normal productive enterprise rather than a prison workshop. The men might be paid a regular wage but required to recompense the institution for the cost of their upkeep.

Presumably all cases would be reviewed by a committee of the staff at regular intervals. The decision to release a patient would include detailed arrangements for the period of re-establishment following his release. The problem presented by patients who appear to be highly unlikely to ever lead a sober and productive life outside of an institution, is discussed below in Section 5.

Halfway houses will be needed for the re-establishment of men returning to urban communities. The difficulties of the transition from life in a closed institution to integrated life in the community have been so well documented that no argument is necessary.

4. Halfway Houses

Halfway houses need to be located in the heart of urban communities, since the men are expected to go out to work and most of the jobs for which they are suited are located in the downtown area.

To perform its function, a halfway house should be reasonably small and probably restricted to a homogeneous group of patients. If it is to be a therapeutic community dependent on the mutual support derived from a small, informal organization oriented to sobriety and employment, it should take advantage of the bonds that already exist between skid row inebriates by supplying halfway houses especially for them. The encouragement of a measure of self-government would seem to be indicated as a form of behaviour therapy to offset years of institutionalized dependence, as well as a means of maintaining morale.

A detailed blueprint for the organization and operation of a halfway house, based on experience elsewhere and the findings of our study, would be desirable, whether the halfway houses are maintained by provincial agencies or local groups. The logical body to provide initiative and guidance would be the Alcoholism and Drug Addiction Research Foundation.

Such a plan should provide for professional counselling for the residents, the involvement of outside organizations in a rehabilitation and recreational program, and, most important, help to the men in finding jobs.

5. Special Provisions for the Permanently Incapacitated

The plan outlined above does not provide for the inebriates who prove to be incapable of returning eventually to independent life in the

community. Two main types will emerge from the sorting out process:

(a) the men who for reasons of old age, physical disabilities, subnormal intelligence, brain damage, etc., need institutional care for the rest of their lives.

(b) the men not incapacitated in these obvious ways, who have, nevertheless, continued to relapse into skid row alcoholism despite all efforts at rehabilitation.

In regard to the first group, it might be argued in opposition to any proposals for special provisions that public facilities already exist to take care of the aged and the disabled. Why, for example, should the other offenders not be sent to homes for the aged? The answer seems to lie in their dependence on the companionship of men like themselves, as well as their dependence on alcohol. Experience has shown that the hard core of this group is unwilling to accept the regimen of a home for the aged and tends to return to skid row life. Similarly, critics might argue that the physically disabled can be taken care of in Seaton House, the facility operated by the Toronto Department of Welfare for such incapacitated, homeless men. Our study has shown that men of this type either avoid going there because they know that they are not allowed to drink or else get expelled for drinking. As a consequence, in Toronto they spend much of their time in a section of the Don Jail known as the Annex, which is set aside especially for these incapacitated offenders. The present system will continue unless they are recognized as a special type of welfare case and provided for accordingly.

Since the residential treatment centres discussed above would be equipped for medical treatment, would provide light work and recreation, and would be physically removed from temptation, we suggest that they be planned with a view to providing accommodation indefinitely for homeless, incapacitated, and apparently incorrigible inebriates.

Membership in the second group would be determined by a process of negative selection. They would be the patients who continued to relapse into skid row alcoholism after they had been exposed to all the available techniques of treatment and rehabilitation. For this group also, the residential treatment centre could provide permanent accommodation and a work program. Some might prove capable of doing work and remaining sober outside of the centre if they could return at nights and on weekends. Some might even be able to do this in an urban setting if decent hostel accommodation, confined to men who are trying to remain sober, were available for permanent residence; suitable arrangements might be made with existing hostels on an experimental basis. Halfway houses might even provide accommodation indefinitely to men that are not otherwise able to get along. In developing methods of dealing with this group of permanently dependent inebriates, a flexible and experimental approach would, once again, be necessary. No North American jurisdiction, to our knowledge, has developed facilities for dealing with this specific group in significant numbers, so there are

no precedents to follow. If nothing is done, the door will continue to revolve relentlessly for these men, as it does elsewhere.

6. Adaptations of the System for Smaller Communities

Sweeping changes using either the public health approach or the traditional penal approach will probably increase the unequal distribution of these facilities between the larger and the smaller centres in the Province. Many specialized facilities are feasible only in urban communities that have a large number of offenders, e.g., detoxication centres, halfway houses, outpatient clinics for this type of inebriate, and probation officers who specialize in dealing with them. For smaller centres, compromise solutions would have to be worked out using the facilities at hand. However, the majority of chronic offenders will be reached directly by facilities located in cities. About 40% of the Ontario repeaters are to be found in the City of Toronto alone. The thirteen judicial districts that contain cities of 50,000 population and over account for 77% of the Ontario recidivists. One effect of the development of expanded facilities in larger communities might be to accelerate the drift of chronic offenders to such centres and thus bring more patients within their ambit. For the majority of these men who lack family and occupational ties, a move to another community is not a major uprooting that would interfere with their rehabilitation.

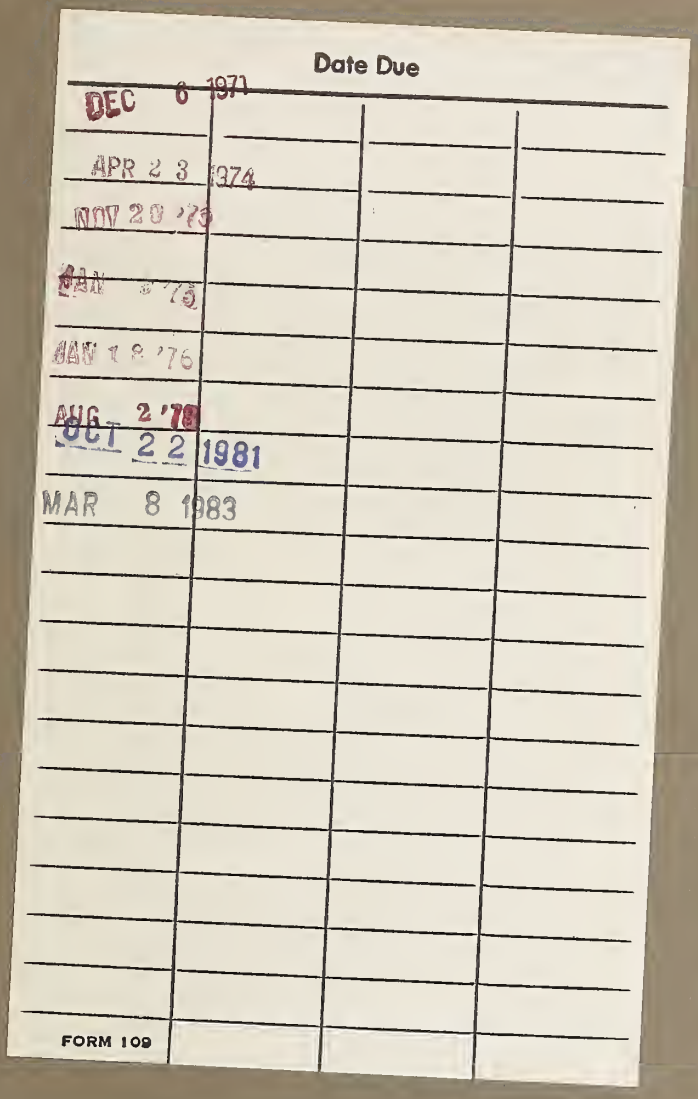
If the public health approach is to be adopted, the police in smaller communities would have to accept a policy of not laying charges against inebriates guilty only of public intoxication but at the same time assume responsibility for seeing that those who are a danger to themselves are taken care of. It would be inequitable to charge inebriates in smaller communities with an offence but not those fortunate enough to be in cities with detoxication centres.

In some communities arrangements might be made with local hospitals to operate within them small detoxication sections to which the police could take inebriates. In many, the policelock-up may be the only place to which homeless drunks can be taken for sobering up. Whatever is done, it is still advisable to provide for medical examination, if not routinely, at least in all cases where the intoxication is severe or there is any reason to suspect other illnesses.

The offenders who are not hospitalized for treatment will have to be released when they are capable of taking care of themselves. This practice, it should be noted, is already followed in some places. Some chief constables of Ontario communities have stated that they commonly book first or occasional offenders as lodgers and release them in the morning. The State of Massachusetts by statute gives probation officers or chiefs of police the right to release any drunkenness offender without laying a charge three times within a year. Apparently the minimum requirements for public order are attained if drunks are removed from the streets but not charged.

APPENDIX D

The chronic public inebriates could be committed for an indefinite period to a residential treatment centre as they would be in the cities. Since there would be no director of a detoxication centre to make the application, this power might be vested in the Chief of Police, with the added safeguard of requiring the equivalent of a pre-sentence report from a probation officer and, perhaps, an opinion regarding the individual's dependence on alcohol from a medical doctor. From this point on, the patient would be dealt with in the same way as his urban counterpart.



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HV 5082 A54 Alcoholism and Drug Addiction Research Foundation of Ontario
Future Management

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HV 5082 A54 Alcoholism and Drug Addiction Research Foundation of Ontario
Future management of alcoholism in Ontario

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